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ABSTRACT

Research has confirmed the link between a number of psychosocial issues (including limited/lacking social networks, learned helplessness, substance abuse, and emotional problems) and homelessness. Research has further established that those psychosocial issues are interlinked by the common denominator of depression, the recognized cognitive treatment of which is similar to the development of self-directed learning (SDL). A pilot study was conducted to examine the value of a new SDL learning module in mitigating the psychosocial factors leading to homelessness. The SDL learning module, which was based on a self-directed group module for adults that was developed by Rutland and Guglielmino, was presented in 10 weekly meetings that were attended by 8 volunteers of an original sample of 27 prospective participants from a homeless shelter. The module's impact on participants' development of SDL readiness was measured by using Guglielmino's Self-Directed Learning Readiness Scale (SDLRS). Of the three individuals who took the SDLRS posttest, only one scored higher on the posttest than on the pretest (earning scores of 256 on the posttest and 243 on the pretest). All three individuals who took both tests credited the learning module with improving their intimate relationships and communication skills. (Contains 50 references.) (MN)

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Self-Directed

Learning Readiness

and

Homelessness

P. F. Matuszowicz

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Abstract

There are a number of psycho-social issues associated with homelessness such as limited or no social networks, learned helplessness, alcoholism and drug abuse and emotional problems. If left unattended these issues are self perpetuating, being of detriment to homeless adults and, if applicable, their children. Ultimately, if ignored, these issues perpetuate the cycle of homelessness itself.

These psycho-social issues are linked by the common denominator of depression. The cognitive treatment of depression and the development of self directed learning readiness are quite similar in approach. In addition, many homeless people are lacking in basic education. Research indicates that this lack of education impacts upon an individual's psychological and economic ability to deal with homelessness.

Hence, the purpose of this pilot study is to determine whether or not homeless individuals consider participation in a self-directed learning (SDL) module to be of value and to measure any increases in self-directed learning readiness that may occur.

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Introduction

Statement of problem.

There are many inter-related problems in life that a typical homeless person has to deal with. Homeless people have no social networks; they suffer from learned helplessness and a variety of associated emotional problems. Abuse, high health risks and lack of education are all problems common to the homeless person's predicament.

The limited social networks of homeless people have been documented in a number of studies (Hutchinson, Stretch, Smith & Kreuger, 1992; Shinn, Knickman & Weitzman, 1991; Sumerlin & Norman, 1992; Dail, 1990; and Bassuk (1990). Weinreb and Bassuck (1990) add that many families, prior to being homeless, live in poor neighborhoods marked by physical and social deterioration. In both cases, this means that homeless families have nowhere to turn in times of crisis. Burn (1992) is clear regarding the "learned helplessness" (p. 1161) that individuals develop from exposure to such social situations and physical environments. No wonder a sense of valuelessness and social isolation are also born of the homeless situation (Ovrebo, 1992; Koegel, 1992; Whitman, Accardo & Sprankel, 1992).

Shelter life is seen to offer little opportunity for an individual to exercise any self determination or self improvement (Farge, 1989; Grunberg and Eagle, 1990; Ovrebo, 1992; Stark, 1992). In addition, the shelter environment as well as homelessness takes a serious toll on children caught up in the cycle (Bassuk and Gallagher, 1990) to the point of seriously softening an individual's identity, (Rivlin, 1990a, 1990b). Furthermore, exposure to the care patterns within a variety of

institutions promotes denial supported by delusion as attested to by Stark (1992), Huttman and Redmond (1991), Rivlin and Imbimbo (1989) and Rivlin (1990b).

These problems lead homeless families to frequently only use health care facilities episodically or during times of crisis which exposes them to high health and psycho-social risks as emphasized by Weinreb & Bassuk (1990) and Rosenman & Stein (1990). Koegel (1992) and Weinreb & Bassuk (1990) also identify individuals who stay on the street in close physical contact with strangers rather than risk the isolation of a hotel or shelter room.

Abuse is another experience common to homeless individuals that results in further social isolation as reason to trust no-one is substantiated (Huttman & Redmond, 1991; Mills & Otta, 1989; Shinn et al., 1991; Tyler, Tyler, Echeverry & Zea, 1991; Dail, 1990; Browne, 1993; Zozus & Zax, 1991; Miner, 1990; Buckner, Bassuk & Zima, 1993; Kruks, 1991).

An incomplete high school education is also associated with the homeless predicament. Studies estimate anywhere from 30% to over 60% of the homeless population completed less than twelve years of schooling (Jahiel, 1992; The Comprehensive Adult Student Assessment System, 1989; Susser, Struening & Conover, 1989; Mills & Otta, 1989).

Rosenman and Stein (1990), Dail (1990) as well as Huttman & Redmond (1991) concur regarding the range and scale of emotional problems exhibited by homeless children (and adults), from aggressive to withdrawn behavior combined with depression, anxiety and stress. All this is compounded by the inability to maintain friendships and exercise the requisite social skills of friendship as a result of living in constant transition.

The nature of these circumstances often leads homeless people to sink into a high level of inactivity instead of proactively facing their situation. To combat this inactivity, obviously, the circumstances that lead to such must be reversed. If homeless individuals exhibited the behaviors / characteristics of the self directed learner as outlined by Steele (1991, p. 179) and Baskett (1991, p. 245), circumstances would be clearly reversed.

Self-directed learning readiness is defined by Steele as having three components:

1. Affective factors which include:
   - -Interest in the subject area to include specific questions about the given topic.
   - -Awareness of information sources that will assist the learning process.
   - -Satisfaction in terms of getting value out of the learning project as she went along and getting value beyond the information received.
   - -Creativity / Self Actualization / Activeness in that she was finding her own information and organizing it herself as opposed to just absorbing something organized and presented by another.
   - -Curiosity with regard to the subject which speaks for itself.
   - -Encouragement from one's peers to include others involved in the same field of learning. "Among the conceptualizations of psychological health that seem to apply in ... *this*... analysis are: attitudes toward ... *one's*... self (and... *one's*... ability); growth, development, and self actualization, inner directedness, successful mastery of the environment" (p. 181).

2. Direct Resources, which Steele correlates with "Learning Resources", to include:

-Informal Networks. That is, making use of the knowledge that other people hold with regard to a given subject area. These people might be friends, relatives or experts in the field.

-Referring to newsletters or books.

-Using consultants who are experts in a given field outside the subject area but are necessary to track down information or in the development of certain techniques that are necessary to complete the given project.

-Exhibits and Conferences which one can attend in the course of learning.

3. Facilitating Resources includes:

-Availing oneself of Electronic Technology.

-Being able to travel when necessary:

-Having the ability to create the appropriate space and time that are prerequisites to learning. Having the confidence and courage to strike out into the heart of unknown territory as it were and not being necessarily bound by past experience or ways of doing things.

Inextricably linked to these factors are certain processes outlined by Baskett (1991, p. 245).

-Verbalizing: Putting meaningful labels on experiences. This is done through conversation with others or as a result of talking to oneself.

-Objectifying: Having the ability to stand aside from oneself in terms of the learning that is taking place and reflect upon one's position as would a

third party.

-Connecting: Linking new ideas or concepts together. Not necessarily in a random fashion.

-Conceptualizing: Organizing newly connected ideas or concepts so as to create a higher level of understanding, to include labeling such frameworks.

-Constructing: An integral part of the conceptualizing process by which an individual is aware of their creations.

-Testing: Whereby new ideas / concepts are discussed with others to check their validity.

-Clarifying: When issues or concepts are recalled to mind after a period of time and refined as the result of new information / experience.

-Idling: Time spent doing other things while still subconsciously thinking about a given issue.

-Freeing Up: Giving oneself the time to idle by letting go competing mental demands.

-Self-Affirmation: The process by which an individual realizes the positive nature of their learning. This includes understanding their own creations and may be initiated intrinsically or extrinsically.

-Re-Valuing: Re-defining existing thinking / attitudes in the light of new learning related to a given issue or coming to a fresh understanding of the same.

Significance of problem.

Current estimates of the number of "literally homeless" range from 0.5 million to 3 million people, while estimates of the "doubled-up" (living in shared accommodation) population range from 2 million to 10 million (Jahiel, 1992, p. 40).

In 1985, families (ie. Parents with dependent children) represented 28 percent of the homeless population. In 1989, this figure had grown to 36 percent of the homeless population (Jahiel, 1992, p. 43). While the very nature of homelessness makes it difficult to collect conclusive data, many people argue that families represent the fastest growing sector of a growing homeless population. The legitimacy of this argument is hard to deny, considering the decline in manufacturing jobs and the increasing number of minimum wage service jobs or temporary jobs, cuts in welfare etc. as outlined by Hamberg & Hopper (1992, p. 231-237).

A reasonable estimated cost to the nation for the first year of dealing with the multitude of problems associated with homelessness runs at $287 billion (Jahiel, 1992a, p. 319).

The one outcome common to all experiences, behaviors and thinking patterns of the homeless, including the associated sense of helplessness and dependency, is depression (Hausman & Hammen, 1993; LaGory, Ritchey & Mullis, 1990; Browne, Siegel & Griffin, 1984; Miner, 1991; Rush, 1983).

Homelessness is also a traumatic experience, described by Goodman, Saxe and Harvey (1991), Miner (1991) and Browne (1993).

Unfortunately, depression and trauma both serve to further exacerbate the sense of helplessness and dependency that are symptomatic of a decrease in the effort an individual puts forth to mitigate the personal circumstances associated with their homeless condition. A conclusive outcome of this situation is the prevalence of alcohol and substance abuse among the homeless: self medication in an effort to relieve the anxiety and stress associated with homelessness (Weinreb & Bassuk, 1990; Farge, 1989; Caslyn & Morse, 1991; Drake et al., 1991).

LaGory et al. (1990, p. 87), report that good health and better education are critical factors in determining the inner strength / mastery required to cope with homelessness. Improved education is probably the foremost outcome of SDL. Better psychological health would be a reasonable outcome of Self-Directed Learning (SDL), while physical health may be expected to improve as a result of psychological health and better planning associated with SDL. Additionally, it is not unreasonable to expect that a diminishing of the social barriers that interfere with the homeless seeking health care would result in better health. Buckner et al. (1993, p. 385), have no doubt that homeless women will suffer economically for longer, unless they are able to improve their ties to relatives and friends.

The following practices are central to a SDL group:

Individuals coming to know and accept one and other as resources for learning.

Individuals identifying the resources they can offer as well as need.

Examining good and bad learning experiences in relation to learning styles and improving self awareness.

Offering and receiving feedback in a constructive manner.

All these practices serve to develop a strong focus on interpersonal behavior and strengthen the ability of individuals to overcome social barriers.

Indeed, the abilities to reason through situations that a SDL module develops should help homeless individuals avoid, perhaps for the first time, what are often recurring situations of detriment. Apart from avoiding detrimental situations, SDL modules provide the opportunity for individuals to practice developing appropriate relationships through the use of role playing, further assisting in the reduction of social barriers by encouraging individuals to understand the feelings of both parties associated with the solicitation of assistance in learning and identifying methods of overcoming hesitation in asking for help. All these activities parallel the accepted cognitive treatment of depression, which focuses on interpersonal skills and dealing with preconceived notions of personal inadequacy.

However, by far the greatest concern must be the cyclical and intergenerational nature of the emotional and behavioral problems associated with homeless families and young homeless adults yet to become parents (Hutmann & Redmond, 1991; Hausman & Hammen, 1993; Bassuk, 1993; Molnar, Rath & Klein, 1990; Browne, 1993).

If we are able develop SDL strategies among the homeless, the impact would not only be felt by the individual, but also by society at large. Indeed, if the homeless individuals developing SDL strategies are parents, the impact would also be felt by the individual's family.

Purpose of Study.

Given that techniques used in the cognitive treatment of depression, in the treatment of trauma and in the development of self-directed learning are similar, Matuszowicz (1995, 1994), the purpose of this pilot study is to determine whether or not homeless individuals consider participation in a self-directed learning module to be of value and to measure any increases in self-directed learning readiness (SDLR) that may occur as a result of such an intervention.

Hypothesis.

The hypothesis, stated in the null form, is there will be no change in the subjects' scores on the Self-Directed Learning Readiness Scale after participation in an intervention designed to increase self-directed learning readiness.

Definitions.

Homelessness is defined as living on the street, in a shelter or in shared private accommodation as a temporary measure. The definition also includes individuals who might be living in motels or hotels, in transition, working to find fresh accommodation comparable to their previous situation.

Trauma is defined as the sudden or unexpected occurrence of a diseased condition of the body or mind, produced by wound, injury, emotional shock, or experience. Such trauma necessitates a major change in lifestyle if it is to be accommodated.

Depression is defined by Rush (1983, p. 49-50) in the following manner:

> Behavior: Crying. Retardation or agitation. Social withdrawal or 'clinging' behavior.

Emotions: Sadness. Anger or irritability. Anxiety. Guilt. Mood swings on a daily basis.

Thinking Patterns: Helplessness - negative view of self. Hopelessness - negative view of the future. Worthlessness - self blame, self criticism. Indecisiveness. Difficulty in concentrating. Suicidal thinking. Hallucinations or delusion, (psychotic depression).

Bodily Symptoms: Disordered sleep (insomnia or hypersomnia). Appetite / weight changes (increase or decrease). Decreased sexual interest / activity. Feeling weak, easily tired, lacking in energy. Menstrual irregularities. Changes in bowel habits (constipation / diarrhea). Aches and pains. Lack of interest in usually enjoyable activities or an inability to experience pleasure.

Self-Directed Learning Readiness is defined as the ability of the learner to recognize his or her learning needs and take personal responsibility for fulfilling those needs.

Assumptions.

1. Subjects will respond honestly to the questionnaire.
2. No other factors will significantly affect the self-directed learning readiness of the subjects during the course of this study.
3. Subjects will be considered "normal" in terms of overall mental health.

Limitations.

All subjects will be voluntary participants, referred by homeless shelters and counselors, once considered suitable for the program. Therefore, perhaps, such individuals may well be predisposed to making more progress than those that refuse to become involved.

Gender, culture, social class, alcohol and drug abuse, educational achievement, income and occupational classification prior to subjects' being homeless are all pertinent factors that will not be accounted for in this particular study. Also, the incidence and degree of subjects' depression will not be accounted for.

Delimitations.

Conclusions drawn from this study will apply to the homeless population from which the sample was drawn.

Method

Subjects.

The adult population from which subjects are to be drawn will be homeless or living in transition.

The sample for this study will be drawn from homeless shelters, halfway houses and counseling centers. Subject backgrounds will be varied in terms of educational achievement, culture, income prior to being homeless, occupational classification, social class, alcohol and drug use / abuse and mental health.

Minimum age of subjects will be eighteen (18) years. There will be no upper age limit. A total of thirty two (32) subjects will participate in this survey.

Instruments.

The Self-Directed Learning Readiness Scale (SDLRS) Guglielmino (1977) will be the instrument for this project. All subjects will be pretested and post tested using this instrument.

"The latest reliability estimate of the SDLR scale, based on a split-half Pearson product moment correlation with Spearman-Brown correction, is .91. The sample consisted of 3,151 individuals from a wide variety of settings throughout the United States and Canada." (Guglielmino, L.M. & P.J., 1991, p. 1).

Subjects will also be asked to complete a small assessment of the module's value to themselves in terms of personal growth, professional growth and their interaction with others.

Treatment.

Subjects will attend eleven weekly meetings, each of approximately one hour duration. The curriculum for these meetings will be taken from a self-directed group module for adults developed by Rutland and Guglielmino (1987).

Subjects will be introduced to the principles of self directed learning and will have an opportunity to demonstrate mastery of these principles by completing a series of self chosen, short SDL projects. Choice of projects will be achieved by using the Solution Therapy approach of DeShazer (1988) as used in questioning by Berg and Hopwood (1991).

Procedure.

Potential volunteers for the program will be recruited through referrals from counselors of homeless shelters that agree to support the project. Thirty two volunteer subjects will be assigned to two treatment groups of sixteen in order of recruitment and depending on the availability of meeting sites. Each group will be pretested at the first of the eleven weekly meetings. After the program has been completed, each group will be post tested.

Analysis.

All subject scores from the post test of the SDLRS will be compared with their pretests on the SDLRS. The mean differences between post test scores and pretest scores will be compared by a two-tailed, independent t-test.

In order for the null hypothesis of this study to be rejected, a significant difference between mean differences of at least .05 must occur.

Results and Discussion

Three area homeless shelters were identified as potential sites for participation in the study. For geographical / travel reasons, two of the three were approached. Of these two, one was willing to participate but felt it inappropriate as they experienced a high turnover of clientele. The director could not see anyone completing the module. i.e.. none of their clients remained in contact with the shelter for 10 - 12 consecutive weeks.

The second shelter that felt it practical to participate in the study is a short stay, emergency shelter, providing services to mothers, single women and men. The shelter provides transitional services for homeless families and individuals. Services include communal sleeping, breakfast and dinner, assistance in contacting appropriate agencies as individual cases require, assistance finding employment and housing. The ultimate goal of the shelter is to see individuals established in employment and maintain their own private accommodation according to need. If possible, after clients leave the shelter, social workers at the shelter maintain contact with clients for a six month follow up period, offering any support clients may need in adjusting to their new life.

In an effort to increase the sample size, participation in the module was offered to the clients of a nearby halfway house. However, this was unsuccessful due to a conflict in schedules that could not be resolved.

Two orientation meetings were held with counselors / staff of the shelter. They were introduced to the module and its contents at the first meeting. The second meeting, a week later, was a question and answer session. This was

considered important in terms of shelter staff promoting the module to their clients.

When offering participation in the study to clients of the shelter, the following criteria were used:

1. That individuals be employed or considered suitable for employment.
2. That individuals have remained in high school until at least the ninth grade exhibiting basic functional literacy skills or have graduated high school.
3. That individuals show no indication of chronic or excessive substance abuse.
4. Length of stay at the shelter was not a factor.

Shelter staff recruited twenty seven (27) prospective participants in the study for a preliminary meeting. At this meeting participants were asked to stand in a circle and pass an imaginary ball around. Some passed on a dead weight, others passed on a feather weight. Sometimes the ball was dropped and the individual picked it up on their own. Other times, if the ball was dropped, the person who dropped it would leave another to pick it up. Sometimes two people helped each other either pass or pick up the ball.

After two or three minutes the group was asked to sit down and comment on how they felt about the exercise. Some were uncomfortable, some enjoyed it, some didn't care either way, some who were uncomfortable in the beginning enjoyed it by the time it was over.

The ball was then likened to education / knowledge. The way we felt about learning / acquiring knowledge was likened to the way the ball was handled. It was explained that the upcoming module would help members of the group better handle the ball and require that people work together in helping each other better handle the ball.

At this point, without sanction, anyone who didn't want to participate in the module was allowed to leave the room. Ten (10) people left the room. The consent form was then distributed and read to seventeen (17) people who all signed as willing to participate in the study. Because of time restraints, a meeting was set for the following week at which the SDLRS pre-test was administered. Ten (10) subjects completed the pre-test and eight (8) showed for the first of ten weekly meetings that comprised the module.

Table One indicates SDLRS pre-test scores, attendance throughout the ten weekly meetings of the module and SDLRS post-test scores where appropriate. "d" denotes the last meeting a subject attended. It is interesting to note that all participants *except* subject 7 had completed high school. Subject eight completed eleventh grade. Subjects one and five received three years and one year of post secondary education respectively.

Table One												
	SDLRS											SDLRS
Subject	Pre-test			Weekly Attendance								Post-test
1	243	P	P	A	P	P	P	P	P	P	P	256
2	190	P	P	A	P	P	P	D				
3	258	P	P	P	D							
4	231	P	P	P	P	P	D					
5	227	P	P	P	A	D						
6	248	P	P	P	P	P	P	D				
7	230	P	P	P	P	P	P	P	A	P	P	227
8	236	P	P	P	P	P	P	P	P	P	P	211
9	214											
10	231											

Table Two indicates the instructor's assessment of subjects attitudes and behaviors during meetings.

Table Two

Subject	Assessment Items				
	1	2	3	4	5
1	H	H	O	P	P
2	L	L	S	Nu	Neg.
3	H	H	N	P	P
4	VL	VL	N	Neg.	Nu
5	VH	VH	A	P	P
6	L	M	S	Nu	Nu
7	H	H	A	P	P
8	VH	VH	O	P	P

Explanation of Table Two assessment Items

1. General level of attentiveness.....Very high: High: Moderate: Low: Very low. Daydreams or falls asleep in class? Pays attention to instructions first time? Spends time doodling?

2. Degree of involvement in conversation / group activities.....

Very high: High: Moderate: Low: Very low.

Takes an active role in group activities and discussions? Takes an active role in main group discussions? Does any background reading?

3. Verbal utterances to the point.....Always: Often: Normally: Sometimes: Never.

Takes a long time to get to the point being made? Conversation contains a lot of material that bears no relevance to the subject of the meeting?

4. Subject's attitude to his or her presence.....Positive: Neutral: Negative.

Happy to be in the group? Feels there's a lot to learn? Already knows everything? Comes to class prepared?

5. General attitude to others.....Positive: Neutral: Negative.

Open minded to the views of others or not? Aggressive in their manner toward others in the group? Discounts others?

General Comments and Observations

The SDLRS pre-test scores were overall a lot higher than expected. One explanation might be the selection process used by shelter workers in offering participation in the study to their clients. Another explanation might be the type of individual an openly avowed short stay shelter attracts. In other words, less self directed individuals might choose to approach known longer term shelters that perhaps demand less of the individual at entry into the system. Both possibilities suggest avenues for further research.

Unfortunately, the SDLRS post-test results set no precedents. Clearly the study needs to be duplicated at other similar homeless shelters. A larger

synthesized sample would permit reasonable statistical analysis of the data collected.

Despite limited statistical results, it is clear from conversation with those who completed the module that it was of use to them. All three clearly stated that participation in the module had helped them better communicate with their significant other. Therefore all three subjects were adamant about the fact that intimate relationships had improved as a result of participation in the module and the concomitant improvement in communication skills.

Table Three contains results of a module assessment completed by subjects at the same time as the SDLRS post-test. Assessment items are detailed below the table. This assessment asked subjects to indicate how they felt the module had helped them, with room for personal comments.

Table Three

	Assessment Items			
Subject	1	2	3a	3b
1	A lot	A lot	A lot	A lot
7	A lot	A lot	A lot	A little
8	A lot	A lot	A lot	A lot

Explanation of Table Three Assessment Items

1. How valuable has this course been in terms of your personal growth?.....

A lot: A little: Not at all.

2. How valuable has this course been in terms of your professional growth?.....

A lot: A little: Not at all.

3. How valuable has this course been in terms of your interaction with others.....

A. At work? A lot: A little: Not at all.

B. Socially? A lot: A little: Not at all.

4. If this program has been of value to you in any other way please specify below.

In the case of the three subjects who completed the module, attitudes and behaviors were clearly positive.

Regarding Item Four, subject One documented improved self awareness, improved problem solving ability and a better perspective on life's overall direction.

Subject Seven documented clearer thinking at home and at work as well as improved problem solving ability.

Subject Eight documented a better understanding of how to solve problems. In particular, this subject was asked by the shelter director how the module had helped them. The subject's response was that they had gone to three banks and questioned the regulations governing checking accounts before opening a free checking account at one of the banks. The subject stated that, before participating in the module they would have walked into the first bank they found and opened a checking account. In this case such action would have meant opening a checking account that carried regular monthly charges. The subject felt that using thinking developed during the course of this module led to an informed decision as opposed to pouncing on the first opportunity that came along.

Of those who did not complete the module, subjects 2, 4 and 6 exhibited poor attitudes and behaviors in varying degrees (See table 3).

Subject 2 left the shelter to co-habit, being thrown on the street after one week. Subject was also receiving out-patient psychiatric care.

Subject 3 was also a perplexing case in that a high SDLRS score was recorded along with very positive attitudes and behavior. Yet the subject exhibited clear signs of depression, severe mood swings and reported regular contact with a psychologist. This subject eventually moved back to their home state to live with parents.

Subject 4 was a perplexing case, remaining in the shelter and exhibiting no discernible change in attitude throughout the contact period. This subject was not prepared to accept any change or do anything for themselves, yet surprisingly, scored average on the SDLRS pre-test.

Subject 5 was a very positive individual with all the appearances of being quite stable. Unfortunately they disappeared without trace.

Subject 6 simply left the shelter to live on the streets again.

Background information, provided voluntarily by participants, was varied but consistent with expectations. Subjects documented histories of childhood abuse and broken families, domestic problems as adults, abandonment, alcoholism and drug abuse. Indeed, subject 9 was 'Baker Acted' before the module began, meaning they were a psychiatric danger to themselves or the community. Subject 10 simply disappeared without trace before the module began. In all cases it was clear that available social networks were limited when it came to getting necessary practical help and services.

Topics of learning chosen during the module (See below) were practical and realistic. Subjects seemed to have no illusions regarding what they must accomplish to better their situations and hence themselves.

Money management

Coping with depression

Accounting skills

How to improve patience

Requirements for working in broadcasting

Issues associated with improving relationships

Aspects of story writing

Presentation of the module went well with the introduction of Brief Solution Therapy goal setting techniques introduced during Session Three. Unfortunately time was lost because participants were not familiar with the technique. It is therefore recommended that an additional session be inserted into the program between sessions Two and Three. This session needs to focus solely on asking participants to identify individuals they are impressed with and perceive to be successful. Having identified a 'role model', participants then need to focus on what things they believe their role models had to learn about to be 'successful'. This would without doubt facilitate a more reasonable transformation of 'dreams' into realistic goals for those not familiar with the technique.

That participants were wholly unreserved about the personal benefits of the module, despite inconclusive SDLRS scores, does pave the way for a further avenue of research, namely that of correlating SDLR & depression.

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If you would be interested in replicating this study so that data could be combined to achieve a statistical conclusion, please write:

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After September 1997, please write:

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